Abstracts

of treatment in a 70 kg individual **Patients underwent EBV screening as part of generic pre-screening bloods.

Abstract PWE-001 Table 1

No of patients screened (n)	Initial treatment agent considered	No of patients in whom treatment was altered (n)	Agent changed to	Average increased cost expenditure per patient
22	Thiopurine	12	Biologic	£9942*
6	Biologic	-	-	-
5	..**	1	Biologic	£4112*
1	Combination therapy	-	-	-

Of the 13 individuals who had their therapy switched 8 (62%) were male and 10 (77%) were Caucasian.

Conclusions Overall EBV naïve status resulted in initiation of therapy different to the initial agent considered in 38% of patients, producing an overall cost expenditure of approximately £1 23 416 with treatment more likely to be switched in male and Caucasian patients.

However, the absolute risk of lymphoma remains low and given the cost, the average age of patients being associated with poorer prognosis and increased likelihood of subsequent antibody development to biologic therapy in patients without initial thiopurine treatment, is the practise of EBV screening in IBD management clinically relevant?

PWE-002 EVALUATING THE ROLE OF MR ENTEROGRAPHY IN THE MANAGEMENT OF PATIENTS WITH CROHN'S DISEASE

Wafaa Ahmed*, Bhavin Kawa, Gautom Baruah, Sukanya Ghosh, Eleanor Warner, Bijay Baburajan. Maidstone And Tunbridge Wells NHS Trust, Kent, UK

10.1136/gutjnl-2018-BSGAbstracts.134

Introduction Magnetic resonance enterography (MRE) is widely available and is being increasingly utilised in the management of patients with Crohn's disease (CD). Free of ionising radiation, it is particularly valuable in sequential imaging. In addition, it is an attractive, non-invasive option in the investigation of patients suspected to have small bowel CD. We sought to investigate whether MRE in patients with CD alters patient management as well as its utility in the diagnosis of CD.

Methods PACS was interrogated to identify patients undergoing MRE across two sites in a trust from March to April 2017. Unique patient IDs were cross referenced with Telepath, Allscripts and Endobase databases for demographic data, results of faecal calprotectin (FC) and clinical outcomes. MR protocol was standardised and calprotectin measurement has been available since 2016.

Treatment change was defined as treatment initiation, escalation or cessation and referral for surgery. Patients being worked up for CD were those that had diarrhoea, abdominal pain or weight loss as their primary indication for MRE.

Results There were 111 MRE carried out over the 3 month period, mean age 38.2 (12–82), male 44 (39.6%), female 67 (60.4%). Of those 57 (51.3%) had established CD and 53

(47.7%) were for investigation of suspected CD. In this group, the results of the MRE influenced the management of 39 cases (68.4%) vs 18 (31.6%) with no change. 30 (52.6%) patients had a new treatment or treatment escalation, 6 (10.5%) had their treatment stopped and 3 (5.3%) were referred for surgery. 24 patients with CD had FC done within 2 months of MRE. Interestingly all of those with a FC <250 ug/g had a normal MRE (n=8).

In patients being worked up for CD, 42 (79.2%) of the MREs were normal and 2 (3.7%) were highly suspicious for CD, the rest showed non-specific inflammation and other findings including liver haemangioma, cholecystitis, jejunal diverticulitis and a carcinoid tumour. Surprisingly, MRE was used as the initial investigation in 9 (16.9%) patients, in which there was one case of cholecystitis but the rest were negative. As in patients with CD, no patient with a FC <250 ug/g had a positive MRE.

Conclusion MRE results influence treatment decisions in CD, facilitating changes in management including withdrawal of biologics. It is seemingly ineffective as a diagnostic test for small bowel CD and calprotectin may be more useful in that context. This study is limited by the exclusion of patients with Crohn's disease who have not had MRE but these findings suggest potential cost savings if MRE is reserved for patients with CD suggested by other means such as faecal biomarkers or endoscopy.

PWE-003 ACETARSOL IS AN EFFECTIVE OPTION IN THE MANAGEMENT OF REFRACTORY PROCTITIS

¹Konstantinos Argyriou*, ¹Richard Ingram, ²Rachel Blatt, ²Patrick Wilson, ¹Sunil Samuel, ¹Christopher Hawkey, ^{1,3}Gordon Moran. ¹Nottingham Digestive Diseases Center, Queen's Medical Centre Campus, Nottingham University Hospitals NHS Trust, Nottingham, UK; ²Pharmacy Department, Queens Medical Center Campus, Nottingham University Hospitals NHS Trust, Nottingham, UK; ³National Institute of Health Research Biomedical Research Centre in Gastrointestinal and Liver Diseases at Nottingham University Hospitals and the University of Nottingham, Nottingham, UK

10.1136/gutjnl-2018-BSGAbstracts.135

Introduction There is an urgent need for superior topical therapy for mesalazine-refractory ulcerative proctitis. Two small preliminary cohort studies have suggested good clinical efficacy data for organic arsenic derivatives such as acetarsol in refractory ulcerative proctitis. Our aim was to describe the effectiveness and tolerability of acetarsol suppositories in a cohort of inflammatory bowel disease (IBD) patients.

Methods We performed a retrospective cohort study by prospectively reviewing maintained clinical records for all patients exposed to acetarsol at the IBD clinic in Nottingham University Hospitals from 2004 to 2017. Response was determined as clinical improvement or improvement in endoscopic appearance. Serum arsenic and C-reactive protein levels were reviewed when available. Non parametric statistical analysis was performed. Data are presented as median and interquartile range

Results 35 patients were prescribed acetarsol suppositories (28 with proctitis, 5 with left-sided colitis, 1 with diversion colitis and 1 with chronic pouchitis). Twenty were males with median age of 44 (34) years and disease duration of 7 (19) years. Nearly all patients had failed mesalazine or corticosteroid-based topical therapy with 20 (57.1%) being refractory to immunotherapy and 3 (8.6%) to anti-TNF therapy. Acetarsol 250 mg bd for at least 4 weeks was prescribed in 75% of the cases. Median treatment duration was 56 days (28). Sixteen